Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules (MARFS), and Provider Bulletins. If there are any services, procedures or text contained in the physicians' Current Procedural Terminology (CPT®) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with MARFS, L&I's rules and policies take precedence (WAC 296-20-010). All policies in this manual apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

For more information on L&I WACs go to
http://www.Lni.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp

For more information on the Revised Code of Washington (RCW) go to
http://search.leg.wa.gov/pub/textsearch/default.asp

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

INTRODUCTION TABLE OF CONTENTS

GENERAL INFORMATION

EFFECTIVE DATE

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2009.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to MARFS will be published on L&I's web site at http://feeschedules.Lni.wa.gov/ under Fee Schedules/Updates & Corrections.

Additional fee schedule and policy information is published throughout the year in L&I's Provider Bulletins that are available at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp

Interested parties may join the L&I Medical Provider News electronic mailing list at http://www.Lni.wa.gov/Main/Listservs/Provider.asp

Listserv participants will receive via e-mail:

- Updates and changes to the Medical Aid Rules and Fee Schedules.
- A link to the new Provider Bulletins as soon as they are posted.
- Notices about courses, seminars, and new information available on L&I's website.

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

Washington State government payers coordinate fee schedule and payment policy development. Billing and payment requirements are as consistent as possible for providers.

The state government payers are:

- The Washington State Fund Workers' Compensation Program administered by the Department of Labor and Industries (L&I).
- The Uniform Medical Plan administered by the Health Care Authority (HCA) for state employees and retirees.
- The State Medicaid Program administered by the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS).

These agencies comprise the Interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own funding source, benefit contracts, rates and conversion factors.

PAYMENT REVIEW

All services rendered to workers' compensation claims are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

HEALTH CARE PROVIDER NETWORKS

The Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow L&I and self-insured employers (collectively known as the insurer) to recommend particular providers or to contract for services. Workers are responsible for choosing their providers. RCW 51.04.030 (2) allows the insurer to recommend to the worker particular health care services or providers where specialized or cost effective treatment can be obtained. However, RCW 51.28.020 and RCW 51.36.010 stipulate that the worker is to receive proper and necessary medical and surgical care from licensed providers of his/her choice.

MAXIMUM FEES NOT MINIMUM FEES

L&I establishes maximum fees for services; it does not establish minimum fees.

RCW 51.04.030 (2) states that L&I shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule. WAC 296-20-010(2) reaffirms that the fees listed in the fee schedule are maximum fees.

BECOMING A PROVIDER

WORKERS' COMPENSATION PROGRAM

A provider must have an active L&I provider account number(s) in order to treat Washington workers and receive payment for medical services. For State Fund claims, this proprietary account number is necessary for L&I to accurately set up its automated billing systems. The provider's federally issued National Provider Identifier (NPI) may be used to bill L&I once the L&I number is established and the NPI is registered with L&I. Either the L&I account number or the NPI can be used with bills and correspondence submitted to L&I. All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure they are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

Providers can apply for:

- L&I account numbers by completing Provider Account Applications (form F248-011-000) *and Form W9s (form F248-036-000). These forms are available at* http://www.becomeprovider.Lni.wa.gov or can be requested by contacting L&I's Provider Accounts section or the Provider Hotline.
- NPIs at https://nppes.cms.hhs.gov/NPPES/Welcome.do .

Contact Information

Provider Accounts
Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
360-902-5140

Provider Hotline
1-800-848-0811

More information about the provider application process is published in WAC 296-20-12401.

KEEP YOUR PROVIDER ACCOUNT UPDATED

Keep us informed of your account changes to prevent payment delays by completing a Provider Accounts Change Form (form F245-365-000). Providers with active L&I accounts are listed on Find-a-Doctor at http://www.lni.wa.gov/ClaimsIns/Claims/FindaDoc/Default.asp.

For self-insured workers' compensation claims contact the insurer directly for provider account number requirements. For assistance in locating self-insurers go to: http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

CRIME VICTIMS COMPENSATION PROGRAM

A provider treating crime victims must apply for a separate provider account with the Crime Victims Compensation Program. Provider Applications (form F800-053-000) and Form W9 (form F800-065-000) for the Crime Victims Compensation Program are available on L&I's web site at http://www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp or can be requested by contacting the Crime Victims Compensation Program. Providers with active Crime Victims Compensation Program accounts are listed on Find-a-Doctor for Crime Victims at https://fortress.wa.gov/lni/fad/FADCSearch.aspx.

Contact Information

Crime Victims Compensation Program
Provider Registration
Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

BILLING INSTRUCTIONS AND FORMS

BILLING PROCEDURES

Billing procedures are outlined in WAC 296-20-125.

BILLING MANUALS AND BILLING INSTRUCTIONS

The *General Provider Billing Manual* (publication F248-100-000) and L&I's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. Providers can request these publications from L&I's Provider Accounts section or the Provider Hotline. (See the Becoming a Provider section above for contact information.)

BILLING FORMS

Providers must use L&I's most recent billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other L&I publications, complete the "Medical Forms Request" (Form F208-063-000) (located under Contact Information on the MARFS CD or on L&I's web site at http://www.Lni.wa.gov/Forms/pdf/208063a0.pdf and send it to L&I's warehouse (address listed on the form). You may also download many forms from L&I's web site at http://www.Lni.wa.gov/FormPub/.

GENERAL BILLING TIPS

This symbol is placed next to billing tips throughout the policy sections to facilitate correct payments.

ADJUSTMENT VS. SUBMITTING A NEW BILL

- When the whole bill is denied, then you need to submit a new bill to be paid for your services.
- When part of the bill is paid, then you must submit an adjustment for the services which were not paid. Additional information on adjustments is available at

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp .

FAILURE TO ATTEND SCHEDULED APPOINTMENT

Workers are expected to attend scheduled appointments. When a worker fails to show for an appointment:

- Per WAC 296-20-010(5) "No fee is payable for missed appointments unless the appointment is for an examination arranged by L&I or self-insurer."
- Workers are advised that a no-show appointment may be grounds for a non-cooperation order.
- Providers are to notify the claim manager immediately when an injured worker fails to show for an appointment.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Submitting State Fund bills, reports and correspondence to the correct addresses helps L&I pay you promptly.

Please do not fax bills.

NOTE: Attending providers have the ability to send secure messages through the Claim and Account Center at http://www.Lni.wa.gov/ORLI/LoGon.asp.

Item	FAX Numbers	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease – Accident Report F242-130-000	ROAs ONLY (360) 902-6690 (800) 941-2976	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, Activity Prescription Forms, reports and chart notes for State Fund Claims and claim related documents other than bills.	(360) 902-4292 (360) 902-4565 (360) 902-4566 (360) 902-4567 (360) 902-5230 (360) 902-6100 (360) 902-6252 (360) 902-6460	Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291 **Reports and chart notes must be mailed separately from bills.**
State Fund Provider Account information updates	(360) 902-4484	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261
UB-04 Forms CMS 1500 Forms Retraining & Job Modification Bills Home Nursing Bills Miscellaneous Bills Pharmacy Bills Compound Prescription Bills Requests for Adjustment	**Do not fax bills**	Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)		Cashier's Office Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. This system cannot read some types of paper and has difficulty passing other types through automated machinery. Documents faxed to the department are automatically routed to the claim file; paper documents are batched and scanned when time is available.

Do's

These tips can help L&I process your documents promptly and accurately.

- Put the patient's name and claim number in the upper right hand corner of each page.
- Submit documents on white 8 ½ x 11-inch paper (one-side only).
- Leave ½ inch at the top of the page blank.
- Submit legible information.
- If there is no claim number available, substitute the patient's social security number.
- Emphasize text using asterisks or underlines.
- Staple together all documents pertaining to one claim.
- Include a key to any abbreviations used.
- Reference only one worker/patient in a narrative report or letter.

Don'ts

Please **do not**:

- Use colored paper, particularly hot or intense colors.
- Use thick or textured paper.
- Send carbonless paper.
- Use any highlighter markings.
- Place information within shaded areas.
- Use italicized text.
- Use paper with black or dark borders, especially on the top border.
- Staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment and can help you avoid repeated requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' individual records to verify the level, type and extent of services provided to workers. The insurer may deny or reduce a provider's level of payment for a specific visit or service if the required documentation is not provided or the level or type of service does not match the procedure code billed. No additional amount is payable for documentation required to support billing.

Providers can submit forms with a signature stamp or an electronic signature from the medical provider. L&I **will not pay** for forms unless they are signed by the provider or authorized representative.

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. These requirements are described in the provider specific sections of this document (MARFS) and in WAC 296-20-06101. The insurer may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix G**.

Amendment of Medical Records
(Policy is based on AHIMA and CMS guidelines.)

Changes to the medical record legally amended prior to bill submission may be considered in determining the validity of the services billed. Changes made after bill submission will not be accepted. If a change to the medical record is made after bill submission, only the original record will be considered in determining appropriate payment of services billed to the department.

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation or clinical services. A late entry, an addendum or a correction to the medical record, must bear the current date of that entry and is signed by the person making the addition or change.

A late entry may be necessary to supply additional information that was omitted from the original entry or to provide additional documentation to supplement entries previously written. The late entry must bear the current date, be added as soon as possible, be written by the provider who performed the original service and only if the provider has total recall of the omitted information.
To document a late entry:

- Identify the new entry as a "late entry".
- Enter the current date and time- do not try to give the appearance that the entry was made on a previous date or an earlier time,
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an "omission", validate the source of additional documentation as much as possible.

An addendum is used to provide information that was not available at the time of the original entry.
To document an addendum:

- Document the current date and time.
- Write "addendum" and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.

When making a correction to the medical record, proper error correction procedures must be followed.

- Draw a line through the entry making sure that the inaccurate information is still legible.
- Initial and date the entry.
- State the reason for the error.
- Document the correct information.

Correction of electronic medical records should follow the same principles of tracking the information.

Falsified Documentation

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered (RCW 51.48.290, 51.48.250). Some examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. You must include subjective and objective findings, records of clinical assessment (diagnoses), reports, interpretations of X-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years (See WAC 296-20-02005).

Providers are required to keep all X-rays for a minimum of 10 years (See WACs 296-20-121 and 296-23-140).

CHARTING FORMAT

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format.

In workers' compensation there is a unique need for work status information. To meet this need L&I suggests that you add **ER** to the SOAP contents.

Chart notes must document:

E Employment issues

Has the worker been released or returned to work?

When is release anticipated?

Is the patient currently working, and if so, at what job?

Include a record of the patient's physical and medical ability to work.

Include information regarding any rehabilitation that the worker may need to undergo.

R Restrictions to recovery

Describe the physical limitations (temporary and permanent) that prevent return to work.

What other limitations, including unrelated conditions, are preventing return to work?

Are any unrelated condition(s) impeding recovery?

Can the worker perform modified work or different duties while recovering (including transitional, part-time, or graduated hours)?

Is there a need for return-to-work assistance?

SOAP-ER CHARTING FORMAT

Office/chart/progress notes and 60-day narrative reports should include the SOAP contents:

S Worker's Subjective complaints

What the worker states, or what the employer, coworker or significant other (family, friend) reports, about the illness or injury. Refer to WAC 296-20-220 (j).

O Objective findings

What is directly observed and noticeable by the medical provider. This includes factual information, for example, physical exam – skin is red and edematous, lab tests – positive for opiates, X-rays – no fracture. Refer to WAC 296-20-220 (i).

A Assessment

What conclusions the medical provider makes after evaluating all the subjective and objective information. Conclusions may appear as

- A definite diagnosis (dx.),
- A "Rule/Out" diagnosis (R/O), or
- Simply as an impression.

This can also include the etiology (ET), defined as the origin of the diagnosis; and/or prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P Plan and Progress

What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment and the plan must state how long the treatment will be administered.

Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to workers. Refer to WAC 296-20-010(7) and WAC 296-20-01002 (Chart notes).

Add **ER** to the SOAP contents to document work status information.

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of L&I's hospital inpatient payment methods. See the Facility Services section, page **166**, or refer to Chapter 296-23A WAC for more information.

Self-insurers (see WAC 296-23A-0210)

Self-insurers use Percentage of Allowed Charges (POAC) to pay for all hospital inpatient services.

All Patient Diagnosis Related Groups (AP DRG)

L&I uses All Patient Diagnosis Related Groups (AP DRG) to pay for most inpatient hospital services.

Per Diem

L&I uses statewide average per diem rates for 5 AP DRG categories:

- Chemical dependency
- Psychiatric
- Rehabilitation
- Medical
- Surgical

Hospitals paid using the AP DRG method are paid per diem rates for AP DRGs designated as low volume.

Percent of Allowed Charges (POAC)

L&I uses a POAC payment method:

- For some hospitals that are exempt from the AP DRG payment method
- As part of the outlier payment calculation for hospitals paid by the AP DRG

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of L&I's payment methods for hospital outpatient services. Refer to Chapter 296-23A WAC and the Facility Services section for more information.

Self-insurers (see WAC 296-23A-0221)

Self-insurers use the maximum fees in the Professional Services Fee Schedule to pay for:

- Radiology,
- Pathology,
- Laboratory,
- Physical therapy and
- Occupational therapy services

Self-insurers use POAC to pay for hospital outpatient services that are not paid with the Professional Services Fee Schedule.

Ambulatory Payment Classifications (APC)

L&I pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

Professional Services Fee Schedule

L&I pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services are paid by a POAC payment method when they are **not paid**

- With the APC payment method,
- The Professional Services Fee Schedule or
- By L&I contract.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (ASC) Rate Calculations

Insurers use a modified version of the ASC payment system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC. Refer to Chapter 296-23B WAC in the Medical Aid Rules and the Facility Services section for more information.

By Report

Insurers pay for some covered services on a by report basis as defined in

WAC 296-20-01002. Fees for by report services may be based on the value of the service as determined by the report.

Max Fees

L&I establishes rates for some services that are not priced with other payment methods.

PAIN MANAGEMENT PAYMENT METHODS

Chronic Pain Management Program Fee Schedule

Insurers pay for Chronic Pain Management Program Services using an all inclusive, phase-based, per diem fee schedule.

RESIDENTIAL FACILITY PAYMENT METHODS

Boarding Homes and Adult Family Homes

Insurers use per diem fees to pay for medical services provided in Boarding Homes and Adult Family Homes.

Nursing Homes, Transitional Care Units and Critical Access Hospitals utilizing swing beds for long term care

Insurers use modified Resource Utilization Groups (RUGs) to develop daily per diem rates to pay for Nursing Home Services.

PROFESSIONAL PROVIDER PAYMENT METHODS

Resource Based Relative Value Scale (RBRVS)

Insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of **R** in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

Insurers pay for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

Average Wholesale Price (AWP)

L&I's rates for covered drugs dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug. Drugs priced with an AWP method have AWP in the Dollar Value columns and a **D** in the fee schedule indicator column of the Professional Services Fee Schedule.

Clinical Laboratory Fee Schedule

L&I's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS. Services priced according to L&I's clinical laboratory fee schedule have a fee schedule indicator of **L** in the Professional Services Fee Schedule.

Flat Fees

L&I establishes rates for some services that are priced with other payment methods. Services priced with flat fees have a fee schedule indicator of **F** in the Professional Services Fee Schedule.

State Fund Contracts

State fund pays for some services by contract. Some of the services paid by contract include:

- Transcutaneous electrical nerve stimulator (TENS) units and supplies,
- Utilization management and
- Chemically related illness center services.

Services paid by contract have a fee schedule indicator of **C** in the Professional Services Fee Schedule.

The Crime Victims Compensation Program does not contract for these services.

By Report

Insurers pay for some covered services on a by report basis as defined in

WAC 296-20-01002. Fees for by report (BR) services may be based on the value of the service as determined by the report. Services paid by report have a fee schedule indicator of **N** in the Professional Services Fee Schedule and BR in other fee schedules.

BILLING CODES AND MODIFIERS

L&I's fee schedules use the federal HCPCS and agency unique local codes.

> **NOTE:** There are no descriptions for CPT® codes and only partial descriptions of HCPCS or CDT codes in the fee schedule. Providers must bill according to the full text descriptions published in the CPT® and HCPCS books. These can be purchased from private sources. Refer to WAC 296-20-010(1) for additional information.

HCPCS Level I codes are the CPT® codes that are developed, updated and copyrighted annually by the American Medical Association (AMA.) There are 3 categories of CPT® codes:

- **CPT® Category I** codes are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, not newly emerging technologies. They consist of 5 numbers (for example, 99201).
- **CPT® Category II** codes are optional and used to facilitate data collection for tracking performance measurement. They consist of 4 numbers followed by an **F** (for example, 0001F).
- **CPT® Category III** codes are temporary and used to identify new and emerging technologies. They consist of 4 numbers followed by a **T** (for example, 0001T).

HCPCS Level I modifiers are the CPT® modifiers that are developed, updated and copyrighted by the AMA. These are used to indicate that a procedure or service has been altered without changing its definition. They consist of 2 numbers (for example, –22). **L&I does not accept the 5 digit modifiers.**

HCPCS Level II codes, commonly called HCPCS (pronounced Hick-Picks), are updated by the Center for Medicare & Medicaid Services (CMS).

HCPCS codes are used to identify:

- Miscellaneous services
- Supplies
- Materials
- Drugs
- Professional services

These codes begin with 1 letter, followed by 4 numbers (for example, K0007).

Codes beginning with **D** are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3).

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered. They consist of 2 letters (for example, –AA) or 1 letter and 1 number (for example, –E1).

Local codes are used to identify unique services or supplies. They consist of 4 numbers followed by 1 letter (except F and T). For example, 1040M must be used to code completion of the Report of Accident and Providers Initial Report forms. L&I will modify local code use as national codes become available.

Local modifiers are used to identify modifications to services. They consist of 1 number and 1 letter (for example, –1S). L&I will modify local modifier use as national modifiers become available.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	**CPT® Category II**	**CPT® Category III**	**HCPCS**	**L&I Unique Local Codes**
Source	AMA / CMS	AMA / CMS	AMA / CMS	AMA / CMS	L&I
Code Format	5 numbers	4 numbers followed by F	4 numbers followed by T	1 letter followed by 4 numbers	4 numbers followed by 1 letter (not F or T)
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter followed by 1 number	1 number followed by 1 letter
Purpose	Professional services, pathology and laboratory tests	Tracking codes to facilitate data collection for tracking performance measurement	Temporary codes for new and emerging technologies	Miscellaneous services, supplies, materials, drugs and professional services	L&I unique services, materials and supplies

CURRENT PROVIDER BULLETINS

Provider Bulletins are temporary communications that give official notification of new or revised rules, laws, coverage decisions, policies, and/or programs that have not been previously published.

Current Provider Bulletins are available on L&I's web site at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

NOTE: If a Provider Bulletin is not listed on L&I's web site, it is no longer current or available.

CURRENT COVERAGE DECISIONS FOR MEDICAL TECHNOLOGIES & PROCEDURES

The following coverage decisions were made by the Office of the Medical Director. See L&I's web site at http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/default.asp for more information.

Coverage Decisions for Medical Technologies & Procedures
This information is current as of March 9, 2009.

Covered by workers compensation?				
Topic	**Yes**			**No**
	With proper documentation	**Only with pre-authorization**	**On a case-by-case basis**	
Acupuncture				X
AquaMED (or dry hydrotherapy)	X			
Artificial disc replacement				X
Autologous blood injections				X
Autologous chondrocyte implantation (ACI)		X		
Bloodborne pathogens	X			
Bone cements for use during kyphoplasty and vertebroplasty				X
Bone growth stimulators		X		
Bone morphogenic proteins (BMP) for long bone nonunions and spinal fusions		X		
Botulinum toxin		X		

Covered by workers compensation?				
Topic	Yes			No
	With proper documentation	Only with pre-authorization	On a case-by-case basis	
Brevio® Nerve Conduction Testing System				X
Cervical traction devices	X			
Ctrac[tm] for CTS wrist splint				X
Discography		X		
Dry needling		X		
Duragesic			X	
Electrical Stimulation for Chronic Wounds		X		
Electrodiagnostic Sensory Nerve Conduction Threshold (sNCT)				X
Electrodiagnostic Testing	X			
Epidural adhesiolysis		X		
ERMI Flexionator and Extensionater				X
Extracorporeal Shockwave Therapy (ESWT)				X
Fibromyalgia				X
Futures Unlimited	X			
Hyaluronic acid	X			
IDET (Intradiscal heating)				X
Implantable Drug Delivery Systems			X	
Interferential therapy units	X (clinical use)	X (home use)		
Low level laser therapy				X
Knee Arthroscopy (for osteoarthritis of the knee)				X
MedX lumbar extension machine	X			
Meniscal allograft transplantation		X		
Microprocessor-controlled prosthetic knees				X
NC-stat® Nerve Conduction System-NeuroMetrix®				X
Neuromuscular electrical stimulators (NMES)	X(clinical use)	X (home use)		
Otto Bock Vacuum Assisted Socket System				X
Percutaneous Discectomy for Disc Herniation				X
Percutaneous Neuromodulation Therapy for low back pain				X
Posterior Lumbar Interbody Fusion (PLIF)		X		
Powered Traction Devices for Intervertebral Decompression	X			
Smoking cessation		X		
Spinal Cord Stimulation				X
Standing, Weight-bearing, Positional & Upright[tm] MRI				X
Transcutaneous Electrical Nerve Stimulator (TENS)	X			
Thermal shrinkage for instability				X
Tinnitus Retraining Therapy				X
UniSpacer				X
Wound VAC			X	
X-STOP® interspinous process device				X